MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1895 CERTIFICATE OF DEATH

Reg. Dist. No. 01909 207

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 235 Lynchburg St.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 37 Chestertown
d. STREET ADDRESS: 235 Lynchburg St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First James — Middle Thomas — Last Bowers

4. DATE OF DEATH: Month Feb. — Day 25, — Year 1957

5. SEX: male

6. COLOR OR RACE: colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 1, 1888

9. AGE (In years last birthday): 68 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer Farmer & Painter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Kent Co. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James H. Bowers

14. MOTHER'S MAIDEN NAME: Edell Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 222-05-3650

17. INFORMANT: Lucy S. Bowers — Address: 235 Lynchburg St. Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive Hemoptysis — INTERVAL BETWEEN ONSET AND DEATH: 1 DAY
DUE TO (b): Carcinoma of Lung c Metastasis — 1 year
DUE TO (c):

163X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diagnosis at Surgery 8/8/56

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11/10, 1956, to 2/24, 1957, that I last saw the deceased alive on 2/24, 1957, and that death occurred at 6 A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas J. Solon M.D. — ADDRESS (Street, city or town, state): Chestertown, Md. — DATE SIGNED: Feb. 25, 1957

PHYSICIAN'S NAME (Type): Thomas J. Solon — Chestertown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Mar. 2, 1957 — 22c. NAME OF CEMETERY OR CREMATORY: Coleman's (Col.) — 22d. LOCATION (City, town, or county) (State): near - Still Pond, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells — ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR — DATE: FEB 27 1957 — 24b. REGISTRAR'S SIGNATURE: Clara Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/5S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01910

1896 **CERTIFICATE OF DEATH**

Reg. Dist. No. 202

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: life
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X1 Chestertown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: RFD # 2
d. STREET ADDRESS: RFD #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First T. Middle Lester Last Bowers

4. DATE OF DEATH: Month Feb. Day 6, Year I957 19

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. II, I887
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: owner
11. BIRTHPLACE (State or foreign country): Kent Co. Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James R. Bowers
14. MOTHER'S MAIDEN NAME: Mary Smythe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 218-20-6125
17. INFORMANT: Thomas Bowers Address: RFD # 2 Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrage — INTERVAL BETWEEN ONSET AND DEATH: 4 hours
DUE TO
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertension
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 6, 1957, to Feb-6, 1957, that I last saw the deceased alive on Feb 6, 1957, and that death occurred at 10:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: E Kester M.D. ADDRESS (Street, city or town, state): Rock Hall DATE SIGNED:

PHYSICIAN'S NAME (Type): Eugene Kester Rock Hall, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 10, 1957
22c. NAME OF CEMETERY OR CREMATORY: Chester Cem.
22d. LOCATION (City, town, or county) (State): Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J Willis Wells ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR DATE: Feb. 11-1957
24b. REGISTRAR'S SIGNATURE: Clara L. Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1902

01911

Reg. Dist. No. 703

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall
c. LENGTH OF STAY IN 1b: (Several Years)

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Rock Hall

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

d. STREET ADDRESS: 1

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth Middle: Edwards Last: Cowperthwaite

4. DATE OF DEATH: Month: Feb. Day: 16, Year: I957 19

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 22, I898

9. AGE (In years last birthday): 58 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Phila., Penna

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Edwards

14. MOTHER'S MAIDEN NAME: Elizabeth Birmingham

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 215-20-0020

17. INFORMANT: James Cowperthwaite Address: Rock Hall, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of breast & metastases
DUE TO
170X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: 11 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 28, 1956, to Feb 16, 1957, that I last saw the deceased alive on Feb 16, 1957, and that death occurred at 3 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard F Smith M.D.
ADDRESS (Street, city or town, state): Rock Hall
DATE SIGNED: 2/16/57

PHYSICIAN'S NAME (Type): Willard F. Smith Rock Hall, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. I8, 1957
22c. NAME OF CEMETERY OR CREMATORY: St. Paul's Cem.
22d. LOCATION (City, town, or county) (State): near - Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J Willis Wells ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR DATE: FEB 19 1957
24b. REGISTRAR'S SIGNATURE: A. Elwood Burgess

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1897 CERTIFICATE OF DEATH

01912

Reg. Dist. No. 3-03

1. PLACE OF DEATH
a. COUNTY: KENT
MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: KENT

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESTERTOWN

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RD 2 ROCK HALL

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: KENT + QUEEN ANNE Co. HOSP

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JAMES Middle NELSON Last CULLEY SR.

4. DATE OF DEATH: Month FEB. Day 27 Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: NOV. 4 - 1900

9. AGE (In years last birthday): 56 yrs.

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WATERMAN

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WM. CULLEY

14. MOTHER'S MAIDEN NAME: MARY HARRISON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-14-7834

17. INFORMANT: James H. Culley Jr. Address: Rock Hall

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12 hours
DUE TO (b): Hypertensive cardiovascular disease — years
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 52 to Feb. 27, 1957, that I last saw the deceased alive on Feb. 26, 1957, and that death occurred at 1 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard F. Smith M.D.
ADDRESS (Street, city or town, state): Rock Hall, Md
DATE SIGNED: 3/4/57

PHYSICIAN'S NAME (Type): WILLARD F. SMITH

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: MAR. 1

22c. NAME OF CEMETERY OR CREMATORY: Wesley CHAPEL

22d. LOCATION (City, town, or county): ROCK HALL (State): MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar R. Thomas ADDRESS: Church Hill Md.

24a. REC'D BY REGISTRAR DATE: March 5, 57

24b. REGISTRAR'S SIGNATURE: S. Elwood Burgess

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01913

Reg. Dist. No. 202

1. PLACE OF DEATH
a. COUNTY 1903 Kent MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chestertown

c. LENGTH OF STAY IN 1b several years

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Rural, Chestertown, Maryland

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural - home

d. STREET ADDRESS /

e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First Ethel Middle Marie Last Doll

4. DATE OF DEATH Month February Day 20 Year 19 57

5. SEX Female

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH 3/8/1902

9. AGE (In years last birthday) 54 yrs.

IF UNDER 1 YEAR Months Days

IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Chicago, Ill.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Arvid Gustafson

14. MOTHER'S MAIDEN NAME Mathilda Swanson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 360-05-1281

17. INFORMANT Carl Doll, Jr. , Address Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) shot gun wound - upper abdomen — INTERVAL BETWEEN ONSET AND DEATH: Instantaneously

976X

DUE TO self-inflicted

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Grasp gun in left hand & shot self in upper abdomen

20c. TIME OF INJURY Hour 1.02 a. m. p. m. Month, Day, Year 2/20 19 57

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home

20f. (City or town) Chestertown (County) Kent (State) Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Robert W. Farr M.D.

EXAMINER'S NAME (Type) Robert W. Farr, M. D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED Feb. 21, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 2/23/57

22c. NAME OF CEMETERY OR CREMATORY Chester Cem.

22d. LOCATION (City, town, or county) (State) Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells ADDRESS Chestertown, Md.

24a. REC'D BY REGISTRAR Feb. 23-57

24b. REGISTRAR'S SIGNATURE Clara L. Barnes

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Block 22 FilmG211 2-28-57 et

1898 **CERTIFICATE OF DEATH**

01914

Reg. Dist. No. 202

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ChesterTown

c. LENGTH OF STAY IN 1b:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2ChesterTown

d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Kent & Queen Annes Hosp.

d. STREET ADDRESS: R.F.D. #2, Box 232

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First — Middle — Last: Freeman

4. DATE OF DEATH: Month: February Day: 18 Year: 1957

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 18, 1957

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: 9 Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Arthur William Freeman

14. MOTHER'S MAIDEN NAME: Lillian Viola Pinkett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mother Address: ChesterTown, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 9 hours
DUE TO
776X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/18/57, 19____, to ____, 19____, that I last saw the deceased alive on 2/18/57, 1957, and that death occurred at ____M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard F. Smith M.D. ADDRESS (Street, city or town, state): Rock Hall, Md DATE SIGNED: 2/18/57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-18-57

22c. NAME OF CEMETERY OR CREMATORY: Melitota

22d. LOCATION (City, town, or county) (State): Melitota, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Family ADDRESS:

24a. REC'D BY REGISTRAR DATE 2-18-57

24b. REGISTRAR'S SIGNATURE: Clara L. Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2072183XVI

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1904 **CERTIFICATE OF DEATH**

01915

Reg. Dist. No. 201

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lynch
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: -----

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Lynch
d. STREET ADDRESS: 1 -----
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Harry — Middle Louis — Last George

4. DATE OF DEATH: Month February — Day 17, — Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May, 6, 1885
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tenant Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nicholas George
14. MOTHER'S MAIDEN NAME: Amanda Cox

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 220-12-0370
17. INFORMANT: Linwood George — Address: Lynch, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cachexia — INTERVAL BETWEEN ONSET AND DEATH: 1 1/2 years

DUE TO
527.2
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Chronic Pulmonary Disease — at least 1½ years
DUE TO
(c) Cystic Disease and Super-imposed Pneumonitis — 2 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/9, 1955, to 2/17, 1957, that I last saw the deceased alive on 2/17, 1957, and that death occurred at 9:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert W Farr M.D.
ADDRESS (Street, city or town, state): Chestertown, Md.
DATE SIGNED: 2-18-57

PHYSICIAN'S NAME (Type): Robert W. Farr

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-19-57
22c. NAME OF CEMETERY OR CREMATORY: Galena Cemetery
22d. LOCATION (City, town, or county) (State): Galena, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Victor N. Kennedy
ADDRESS: Still Pond, Md.
24a. REC'D BY REGISTRAR DATE: 2/18/57
24b. REGISTRAR'S SIGNATURE: E Kennard Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1899 CERTIFICATE OF DEATH

Reg. Dist. No. 01916 287

1. PLACE OF DEATH
a. COUNTY: KENT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESTERTOWN
c. LENGTH OF STAY IN 1b: 13 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: KENT+QUEEN ANNE'S HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 RURAL WORTON
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY — Middle OHTSEY — Last RINGGOLD

4. DATE OF DEATH: Month Feb — Day 9 — Year 1957

5. SEX: F

6. COLOR OR RACE: Col

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUG. 17, 1893

9. AGE (In years last birthday): 63 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SAMUEL STANLEY

14. MOTHER'S MAIDEN NAME: RACHEL BUTLER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT — Address: J. RINGGOLD WORTON, MD. R.F.D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STROKE + UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

260X

DUE TO (b) KIMMELSTIEL-WILSON DISEASE — 1-3 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) DIABETIES MELLITUS — Don't know

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-26, 1957, to 2-9, 1957, that I last saw the deceased alive on 2-9, 1957, and that death occurred at 3:40 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert W. Farr M.D. — ADDRESS (Street, city or town, state): Chestertown, Md — DATE SIGNED: 2/9/57

PHYSICIAN'S NAME (Type): ROBERT W. FARR

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 22b. DATE THEREOF: 2-12-57 — 22c. NAME OF CEMETERY OR CREMATORY: FOUNTAIN CEMTY — 22d. LOCATION (City, town, or county) (State): WORTON, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Victor N. Kennedy — ADDRESS: STILL POND, MD.

24a. REC'D BY REGISTRAR DATE: 2/11/57 — 24b. REGISTRAR'S SIGNATURE: E Kennard Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01917

1905 **CERTIFICATE OF DEATH**

Reg. Dist. No. 207

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: life

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Chestertown
d. STREET ADDRESS: 1 RFDS #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: RFD # 2 (Georgetown)

3. NAME OF DECEASED (Type or print): First: Albert Middle: Scott, Lost: Jr.

4. DATE OF DEATH: Month: 2/4/57 Day: Year: 19

5. SEX: male

6. COLOR OR RACE: colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 9, 1908

9. AGE (In years last birthday): 48 yrs.

IF UNDER 1 YEAR / IF UNDER 24 HRS.: Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farm and other

11. BIRTHPLACE (State or foreign country): Kent Co. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Albert Scott, Sr.

14. MOTHER'S MAIDEN NAME: Lula Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-16-5168

17. INFORMANT: Gustavia Scott — Address: RFD 2 Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Oedema
DUE TO (b): Carcinomatosis of Stomach
DUE TO (c):

151X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Myocarditis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 20, 1956, to Feb 4, 1957, that I last saw the deceased alive on Feb 3, 1957, and that death occurred at 7P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Norbert C. Nitsch M.D. — ADDRESS (Street, city or town, state): Rock Hall, Md. — DATE SIGNED: 2/5/57

PHYSICIAN'S NAME (Type): Norbert C. Nitsch - Rock Hall, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 9, 1957

22c. NAME OF CEMETERY OR CREMATORY: Georgetown Cemetery

22d. LOCATION (City, town, or county) (State): Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells — ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR DATE: FEB 11 1957

24b. REGISTRAR'S SIGNATURE: Clara L. Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1906 CERTIFICATE OF DEATH

Reg. Dist. No. 01918 2 03

1. PLACE OF DEATH
a. COUNTY: KENT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCK HALL
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — COUNTY: KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 ROCK HALL
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALVIN Middle LLOYD Last SHRECK
4. DATE OF DEATH: Month Feb. Day 8 Year 1957

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 30 - 1892
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WATER MAN
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank Shreck
14. MOTHER'S MAIDEN NAME: C. Emma Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 215-22-0687
17. INFORMANT: Mrs. Mary Shreck — Address: Oak Hall, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH:
420.1
DUE TO (b): Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Arterio Sclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 8, 1957, to Feb 8, 1957, that I last saw the deceased alive on Feb 8, 1957, and that death occurred at 7 35 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Norbert C. Nitsch M.D. ADDRESS (Street, city or town, state): Rock Hall Maryland DATE SIGNED:
PHYSICIAN'S NAME (Type): NORBERT C. NITSCH

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 2/10/57
22c. NAME OF CEMETERY OR CREMATORY: St. Johns
22d. LOCATION (City, town, or county) (State): Rock Hall Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar L. Lane ADDRESS: Church Hill, Md.
24a. REC'D BY REGISTRAR DATE: 2/10/57.
24b. REGISTRAR'S SIGNATURE: A. Elwood Burgess

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1900

Reg. Dist. No. 01919

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 2½ months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent and Queen Anne Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-------Chestertown, Md. ×2
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Nettie M. Middle Last Sutton
4. DATE OF DEATH: Month Feb. Day 23 Year 19 57

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 28, 1880
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Kent Co., Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John W. Hersch
14. MOTHER'S MAIDEN NAME: Emily Stevens (Emily)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Linwood Sutton, Address Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebral hemorrhage	5 mos.
442× DUE TO (b)	Cardiovascular renal disease	not known
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Hypertension	not known

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Carcinoma right breast

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-9, 19 56, to 2-23, 19 57, that I last saw the deceased alive on 2-23, 19 57, and that death occurred at 8:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: a.c. Dick M.D.
ADDRESS (Street, city or town, state): Chestertown, Md.
DATE SIGNED: 2-25-57
PHYSICIAN'S NAME (Type): A.C. Dick

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 26, 1957
22c. NAME OF CEMETERY OR CREMATORY: Chester Cem.
22d. LOCATION (City, town, or county) (State): Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells
ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR DATE: FEB 27 1957
24b. REGISTRAR'S SIGNATURE: Chas. H. Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar priar to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1901 **CERTIFICATE OF DEATH**

01920

Reg. Dist. No. 2-1

M

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 2 Hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Anne's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ×2 Betterton
d. STREET ADDRESS: *****
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Emma — Middle Anderson — Last Sykes

4. DATE OF DEATH: Month February — Day 21, — Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 20, 1875

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Frank Anderson

14. MOTHER'S MAIDEN NAME: Henrietta Gordon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: None

17. INFORMANT: William Sykes — Address: Betterton, Md.

I

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 6 h
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Acute left ventricular Failure — 10 h
DUE TO
(c): Myocardial infarction — 1 year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertensive & arteriosclerotic C.V. Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept, 1955, to Feb, 1957, that I last saw the deceased alive on Feb 21, 1957, and that death occurred at 11:30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Florence Deringer Joyce M.D.
ADDRESS (Street, city or town, state): Worton, Md.
DATE SIGNED: 2/21/57

PHYSICIAN'S NAME (Type): Florence Deringer Joyce — Worton Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/24/57
22c. NAME OF CEMETERY OR CREMATORY: Still Pond Cemetery
22d. LOCATION (City, town, or county) (State): Still Pond, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Victor N. Kennedy
ADDRESS: Still Pond, Md.

24a. REC'D BY REGISTRAR DATE: 2/25/57
24b. REGISTRAR'S SIGNATURE: C Kenard Jones

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01921

Item 7 Film G210 2-15-57 et

Reg. Dist. No. 202

1. PLACE OF DEATH
a. COUNTY 1907 KENT MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chestertown
c. LENGTH OF STAY IN 1b: 2-3 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Chestertown - X2
d. STREET ADDRESS 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LEVEN Middle BALDWIN Last TRICE

4. DATE OF DEATH: Month Feb Day 6 Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 5-1888
9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer - Farming
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: James Trice
14. MOTHER'S MAIDEN NAME: Martha Adkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 164-16-7879
17. INFORMANT: Leona A. George Address: Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 hours
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Felt indigestion about noon - Found dead about 5 pm
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Robert W. Farr M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) ROBERT W. FARR
DATE SIGNED 2/6/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 11, 1957
22c. NAME OF CEMETERY OR CREMATORY: Chester Cemetery
22d. LOCATION (City, town, or county) (State): Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Willis Wells ADDRESS: Chestertown. Md.
24a. REC'D BY REGISTRAR DATE: Feb. 9-1957
24b. REGISTRAR'S SIGNATURE: Clara L. Barnes

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain on certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for [redacted] files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01922

Reg. Dist. No. 203

1908

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Joseph Lawrence

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Rock Hall Md
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First (LONNIE) Middle Last WHALAND
4. DATE OF DEATH: Month 2 Day 9 Year 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 5, 1903
9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Samuel
14. MOTHER'S MAIDEN NAME: Elelene Everett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 220-12-2406
17. INFORMANT: Address: Mildred Whaland Rock Hall, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Probable drowning
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: None
929.8

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Drinking, Disappeared yesterday about 5:30 pm Found in water today noon
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): River shore
20f. (City or town) Rock Hall (County) Kent (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Robt W Farr M.D.
EXAMINER'S NAME (Type): ROBERT W. FARR
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
DATE SIGNED: 2/9/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/12/57
22c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel
22d. LOCATION (City, town, or county) (State): Rock Hall Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar L Lane
ADDRESS: Church Hill
24a. REC'D BY REGISTRAR DATE: 2/12/57
24b. REGISTRAR'S SIGNATURE: Elwood Bruce

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01923

1909

CERTIFICATE OF DEATH

Reg. Dist. No. 200

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millington
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Chesterville Forest RFD 2

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Millington RFD # 2
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Annie — Middle Eliza — Last Woodland

4. DATE OF DEATH: Month Feb. — Day 3, — Year I957

5. SEX: female

6. COLOR OR RACE: colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 25, I88I

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Wilson

14. MOTHER'S MAIDEN NAME: Janie Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: no

17. INFORMANT: Henrietta Burke — Address: RFD # 2 Millington, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 weeks

422.2
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Degeneration of heart muscle — for years.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 2, 19 57, to Feb. 3, 19 57, that I last saw the deceased alive on Feb. 2, 19 57, and that death occurred at 6-30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Geza Koralewski M.D. — ADDRESS (Street, city or town, state): Millington, Md. — DATE SIGNED: Feb. 3, I957

PHYSICIAN'S NAME (Type): Geza Koralewski — Millington, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 7 I957

22c. NAME OF CEMETERY OR CREMATORY: Morgnec Cemetery

22d. LOCATION (City, town, or county) (State): nr. Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Willis Wells — ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR — DATE: FEB 6 1957

24b. REGISTRAR'S SIGNATURE: Eliz. Mulford

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55